HOUSE BILL No. 1172

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-1-20; IC 27-8-10-2.1.

Synopsis: ICHIA fee. Requires insurers that do business in Indiana and that pay the insurance premium tax to pay an Indiana comprehensive health insurance association (ICHIA) fee with a five year phase in period. Authorizes an insurer that pays the ICHIA fee to take a tax credit for the full amount of the ICHIA fee. Exempts special purpose assessments, including the ICHIA fee and the ICHIA assessment, from Indiana's retaliatory insurance provisions.

Effective: January 1, 2002 (retroactive).

Fry

January 9, 2002, read first time and referred to Committee on Insurance, Corporations and Small Business.

Introduced

Second Regular Session 112th General Assembly (2002)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2001 General Assembly.

HOUSE BILL No. 1172

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-1-20-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002 (RETROACTIVE)]: Sec. 12. (a) When, by the laws of any other state, any taxes, fines, penalties, licenses, fees, deposits of money or securities, or other obligations or prohibitions are imposed upon insurance companies of this or other states, or their agents, greater than are required by laws of this state, then the same obligations and prohibitions, of whatever kind, shall, in like manner for like purposes, be imposed upon all insurance companies of such states and their agents. All insurance companies of other nations, under this section, shall be held as of the state where they have elected to make their deposit and establish their principal agency in the United States. **This subsection does not apply to special purpose assessments, including Indiana comprehensive health insurance association fees charged under section 35 of this chapter and Indiana comprehensive health insurance association assessments charged under IC 27-8-10.**

(b) Whenever it shall be made to appear to the insurance

commissioner that permission to transact business within any state of the United States, other than the state of Indiana, or within any foreign country, is refused to an insurance company organized under the laws of this state, after a certificate of the solvency and good management of such company has been issued to it by the insurance commissioner and after such company has complied with any reasonable laws of such other state or foreign country requiring deposits of money or securities with the government of such other state or foreign country, then and in every such case, the commissioner may forthwith cancel the authority of every insurance company organized under the laws of such other state or foreign country and licensed to do business in this state, and may refuse a certificate of authority to every such company thereafter applying to him for authority to do business in this state, until his certificate shall have been duly recognized by the government of such other state or foreign country.

SECTION 2. IC 27-1-20-35 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002 (RETROACTIVE)]: **Sec. 35. (a) Each year, an insurance company that does business in Indiana and files a report under IC 27-1-18-2 shall, at the time the report is filed, pay to the Indiana comprehensive health insurance association established by IC 27-8-10-2.1 an Indiana comprehensive health insurance association fee equal to the amount of gross premiums for the year, less the allowable deductions provided for under subsection (b), multiplied by the following rate for the year the report covers:**

(1) For 2001, one-tenth percent (0.1%).

(2) For 2002, two-tenths percent (0.2%).

(3) For 2003, three-tenths percent (0.3%).

(4) For 2004, five-tenths percent (0.5%).

(5) For 2005 and thereafter, seven-tenths percent (0.7%).

(b) The calculation of an insurance company's Indiana comprehensive health insurance association fee under subsection (a) shall be based on the gross amount of all premiums received by the insurance company on policies of insurance covering risks in Indiana or, in the case of marine or transportation risks, on policies made, written, or renewed in Indiana during the twelve (12) month period ending December 31 of the preceding calendar year. The following shall be deducted from the amount of gross premiums described in this subsection:

(1) Consideration received for reinsurance of risks in Indiana from companies authorized to transact an insurance business in Indiana.

(2) The amount of dividends paid or credited to resident insureds or used to reduce current premiums of resident insureds.

(3) The amount of premiums actually returned to residents on account of applications not accepted or on account of policies not delivered.

(4) The amount of unearned premiums returned on account of the cancellation of policies covering risks in Indiana.

(c) An insurer that pays the Indiana comprehensive health insurance association fee under this section may take a credit equal to the amount of the fee paid against:

(1) premium taxes under IC 27-1-18-2;

(2) gross income taxes under IC 6-2.1;

(3) adjusted gross income taxes under IC 6-3-1 through IC 6-3-7;

(4) supplemental corporate net income taxes under IC 6-3-8; or

(5) any combination of these or similar taxes;

on revenues or income of the insurer that may be imposed by the state, up to the amount of the taxes due for each calendar year in which the Indiana comprehensive health insurance association fee was paid, and for succeeding years until the aggregate of the fees has been offset by credits against the taxes.

(d) Indiana comprehensive health insurance association fees collected under this section shall be retained by the Indiana comprehensive health insurance association established by IC 27-8-10-2.1 and may be used only to pay the cost of providing coverage under association policies (as defined in IC 27-8-10-1) that exceeds premiums collected by the association.

SECTION 3. IC 27-8-10-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002 (RETROACTIVE)]: Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of seven (7)

members whose principal residence is in Indiana selected as follows:

(1) Three (3) members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.

(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.

(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.

The commissioner shall appoint the chairman of the board, and the board shall elect a secretary from its membership. The term of office of each appointed member is three (3) years, subject to eligibility for reappointment. Members of the board who are not state employees may be reimbursed from the association's funds for expenses incurred in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. The plan of operation must:

(1) establish procedures for the handling and accounting of assets and money of the association;

(2) establish the amount and method of reimbursing members of the board;

(3) establish regular times and places for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;

(5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;

(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

(d) The plan of operation may provide that any of the powers and duties of the association be delegated to a person who will perform functions similar to those of this association. A delegation under this section takes effect only with the approval of both the board of directors and the commissioner. The commissioner may not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

(1) Enter into contracts as are necessary or proper to carry out this chapter, subject to the approval of the commissioner.

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

(3) Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.

(4) Establish a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.

(6) Pool risks among members.

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

(9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(f) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification may not be more than one hundred fifty percent (150%) of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year. In determining the average rate of the five (5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits identical to those issued by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) Following the close of the association's fiscal year, the association shall determine:

(1) the net premiums;

(2) the total amount of Indiana comprehensive health insurance association fees collected under IC 27-1-20-35;

(3) the expenses of administration; and

(4) the incurred losses;

for the year. Any net loss shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums, excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association or any other equitable basis as may be provided in the plan of operation. For self-insurers, health maintenance organizations, and limited service health maintenance organizations that are members of the association, the proportionate share of losses must be determined through the application of an equitable formula based upon claims paid, excluding claims for Medicaid contracts with the state of Indiana, or the value of services provided. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the association's next fiscal year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by the commissioner.

(h) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations by an independent certified public accountant.

(i) The association is subject to examination by the department of insurance under IC 27-1-3.1. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(j) All policy forms issued by the association must conform in substance to prototype forms developed by the association, must in all other respects conform to the requirements of this chapter, and must be filed with and approved by the commissioner before their use.

(k) The association may not issue an association policy to any individual who, on the effective date of the coverage applied for, does not meet the eligibility requirements of section 5.1 of this chapter.

(l) The association shall pay an agent's referral fee of twenty-five dollars ($25) to each insurance agent who refers an applicant to the association if that applicant is accepted.

(m) The association and the premium collected by the association shall be exempt from the premium tax, the gross income tax, the adjusted gross income tax, supplemental corporate net income, or any combination of these, or similar taxes upon revenues or income that may be imposed by the state.

(n) Members who after July 1, 1983, during any calendar year, have paid one (1) or more assessments levied under this chapter may either:

(1) take a credit against premium taxes, gross income taxes, adjusted gross income taxes, supplemental corporate net income taxes, or any combination of these, or similar taxes upon revenues or income of member insurers that may be imposed by the state, up to the amount of the taxes due for each calendar year in which the assessments were paid and for succeeding years until the aggregate of those assessments have been offset by ~~either~~ credits against those taxes; ~~or refunds from the association;~~ or

(2) ~~any member insurer may~~ include in the rates for premiums charged for insurance policies to which this chapter applies amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

(o) The association shall provide for the option of monthly collection of premiums.

SECTION 4. [EFFECTIVE JANUARY 1, 2002 (RETROACTIVE)] **The first payment made under IC 27-1-20-35(a), as added by this act, is due not later than July 1, 2002, and is based on the insurance company's gross premiums for calendar year 2001.**

SECTION 5. **An emergency is declared for this act.**